

Stedman (H. R.)

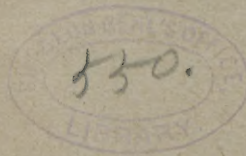
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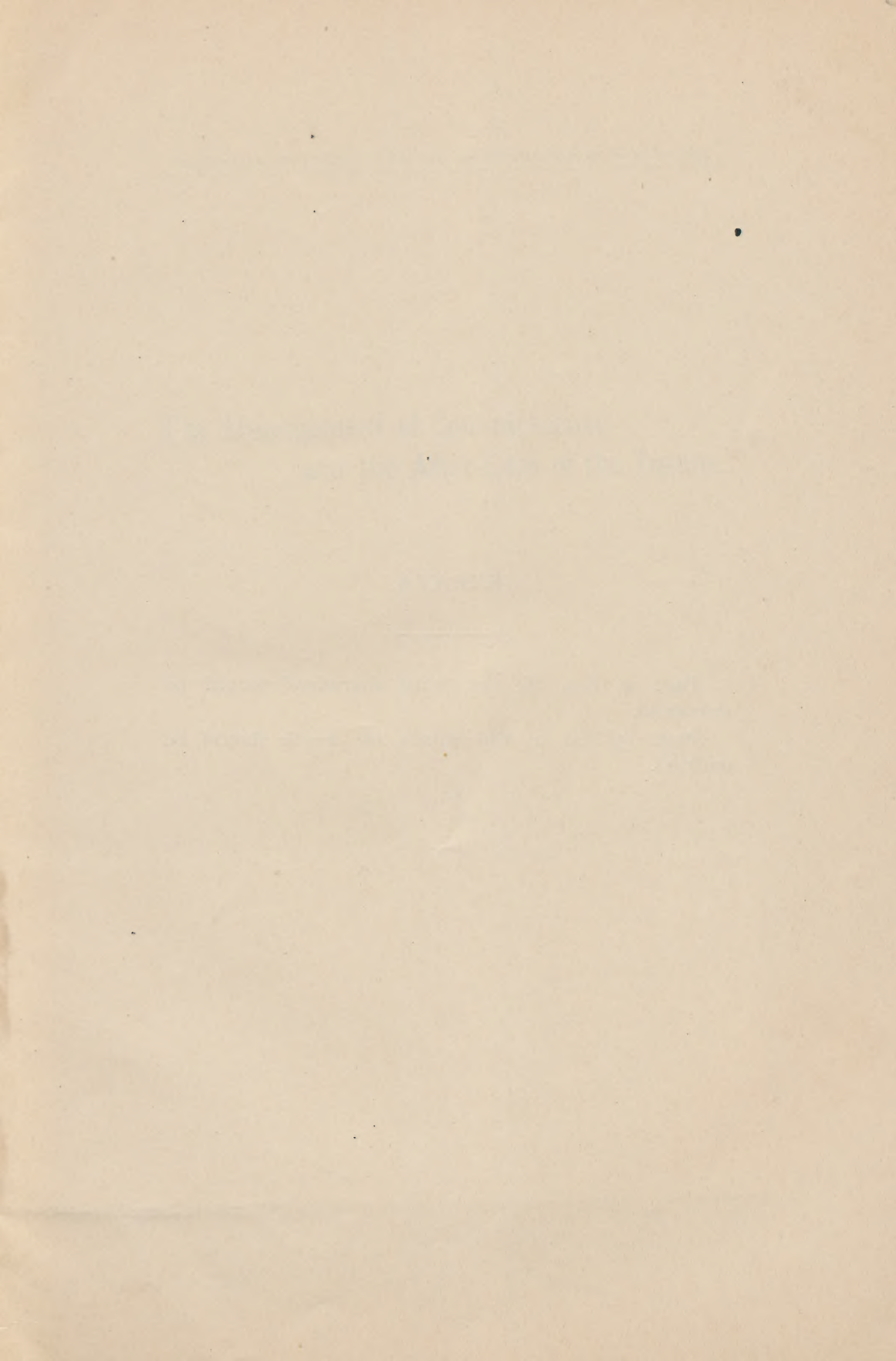
The Management of Convalescence
and the After-care of the Insane.

BY

HENRY R. STEDMAN, M. D.,

Boston, Mass.





ERRATA.

Page 4, line 26, the word *determined* should be *determines*.

Page 13, line 2, the words *the lunatic* should be omitted.

With the Compliments of

THE AUTHOR.

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THE MANAGEMENT OF CONVALESCENCE AND THE AFTER-CARE OF THE INSANE.¹

By HENRY R. STEDMAN, M.D.,

Boston, Mass.

THE dangers besetting convalescence from attacks of insanity, and the precautions necessary to prevent relapse or to prolong remissions, as well as the care of this class of patients during the critical year or two following recovery, are important enough to receive special attention.

Disregard of general advice as to prevention of insanity in the person and offspring of the predisposed:—

The soundest arguments and the most appalling examples have long been furnished us, of the results of disobedience of natural laws by the marriage of the mentally unfit. We are also told a great deal of proper physical and mental training, and the best of rules are given for the guidance of those who are delicate mentally through hereditary or acquired predisposition. But we all know how little general rules for the prevention of insanity appeal to the individual until the incipient symptoms of that disorder become evident, when it is usually too late to help. Often, to be sure, actual prevention by the most painstaking individual care, from the first, would be impossible in subjects saturated with hereditary taint, even could we foresee with certainty upon which individual of a family the blow would fall, as the diminishing capacity for normal mental life, would sooner or later find its limit. But it is certainly reasonable to expect that proper precautions as to education and manner of living, would be the direct cause in setting that limit farther ahead.

¹ Read before the American Neurological Association, Washington, D. C., May, 1894.

Patients alive to danger only after experiencing an attack:—

Physicians are seldom consulted on such possibilities, and when through fear or duty the subject is approached, the fact of previous insanity in the individual or his family is concealed or belittled by the relatives, and delicate mental health either threatened or feared is ascribed to other causes. But when once an attack has occurred both relatives and patient are for a time at least amenable to advice and, indeed, sometimes over-cautious. Here, then, we have a field of real usefulness in the way of preventive treatment, and we may be reasonably sure that our advice will be followed in the main, in the case of intelligent patients. If this be given before the patient leaves the physician's hands, with the object-lesson fresh in mind, such counsel is likely to be remembered and acted upon.

If, then, as is generally admitted, prevention of a possible attack in persons who are merely predisposed to insanity, is so important that no physician would neglect the rare opportunity to help, how much more vital and practically helpful is the duty of endeavoring to ward off attacks from those whose minds have already been disordered, and who will welcome and heed advice directed toward the prevention or delay of a recurrence of the dreaded malady.

Management of convalescence often determined the question of second attack or length of remission:—

We have often been impressed with the power for health of longer or shorter duration or for confirmed dementia that has lain in the manner of conducting convalescence from mental disease. Beyond protecting them from harm to themselves and others, and administering to their bodily needs, we can often do little for the insane in the early stages of an attack of acute mania or melancholia. It is when the severity of the attack has passed and the weakened mind and, perhaps, still partially perverted senses are endeavoring to readjust themselves to the old impressions and experiences, that moral or psychical treatment is of real use, and when the

right influences and surroundings are all-powerful for the health of the mind.

In the case of sane patients who are phthisically inclined we take pains to give the most careful directions regarding exposure, fatigue, diet, change, etc., in order to prevent the return of alarming symptoms; yet how seldom is similar caution given to the convalescent or recently recovered insane person.¹

This preface seems called for to answer possible criticism for presenting a subject which in itself seems to have been thought hardly worthy of attention in medical literature. We know of but one (a recent work)² which gives separate consideration to convalescence, a period when, by the way, the insane frequently come into the hands of the family physician or neurologist.

Short convalescences and sudden recoveries:

Instances of abrupt recovery with practically no convalescent period do occur on rare occasions, and it is well to bear in mind such a possibility. They may be looked for chiefly in cases of short duration (a few months for example) which have a neurasthenic basis, history and symptoms of overstrain, etc. Acute confusional insanity, transitory mania and melancholia have been the more common forms, although cases of acute paranoia are reported.³ So also the toxic and neurotic forms, as might be expected, viz., alcoholic, hysterical and epileptic insanity. It would seem that physical complications sometimes affected not only the suddenness but the fact of recovery. Headache, backache, indigestion, etc., are favorable signs even before actual convalescence becomes evident in noticeable mental improvement. Sudden cures following intercurrent pleurisy, erysipelas, fevers, hæmorrhages, injuries, attempts at suicide, we have all heard of. It is, however, doubtful how much diseases and shocks are a help in insanity, although they no doubt exert a distinct influence in certain cases.

¹ See page 796.

² Hand book of Insanity—Kirchoff, 1893.

³ Peretti, Allgemeine Zeitsch für Psych., xlv, 1889, p. 62.

Lucid intervals; spurious convalescence:—

With experience, however, we become sceptical of sudden returns of reason, gradual improvement being the almost invariable rule and slowly advancing recoveries the more certain. Spurious convalescence is common, however, and very deceptive. A recent case in the writer's care, on two occasions awoke in the morning after a disturbed night and long season of violent mania, apparently entirely rational and cognizant of much of her morbid experience. She resumed her ordinary habits of life in the household. The first interval occurred at home, and lasted a day or two; the second at "Woodbourne," and lasted a week or ten days under enforced quiet. Both intervals, however, were followed by intense excitement, which appeared with equal suddenness. These intervals are very deceptive, and embarrassments and disappointment to all concerned will often be saved, we have thought, and a premature prognosis avoided by the observation of the patient's sleep, as we have always found in such intervals that the sleep continued to be no better, if it did not grow actually poorer, at such times, however much the patient's appetite, strength and control may have been improving. Careful observation will sometimes, also, reveal smouldering delusions or hallucinations ready to break out at any time. Where the attack has been maniacal there is apt to be, also, an undue restlessness or vivacity at this time which is foreign to the patient's normal condition. Lucid intervals are not without significance, however, as they have appeared in the course of many cases that have made good recoveries.

Signs of true convalescence:—

The cardinal symptoms of true convalescence—improvement in sleep, general health, composure and interest, recognition of former delusions as such, mental improvement keeping pace with physical gain, return of menses, etc.—are well known, but there is, to our mind, no surer sign (and it is by no means uncommon) than the cessation of decided fear of a return of the attack, and of

the patient's mortification at the supposed stigma which their insanity has fastened upon them. It is no uncommon thing for patients to speak and write to their friends with freedom of their recent experience, and even of the place where their disorder has been treated, as if it had been a physical disease. While it is to a large extent true that for a time such a patient is looked at askance by others as having been once insane, the patient himself has rarely such mortification as would be supposed to follow. We have confirmed this view by frequent inquiries.

Importance of familiarity with the immediate prodromata of an attack and minor conditions natural to the patient in health:—

In estimating the value of symptoms which are apparently those of convalescence, a knowledge of the patient's mental and physical condition immediately preceding the attack is important. The favorable changes noticed in disposition and character are familiar to all, but not enough stress has been laid, we think, upon ailments to which the patient had always been subject in health, but of which there was no evidence during insanity—for example, "nervous headache," backache, digestive disturbances, etc. For guarding against relapse a precise knowledge, also, of the *sequence* of prodromata in individual cases is especially useful, as an attack often passes off in repeating the steps of progress to insanity in inverse order. A convalescing patient of the writer's is now experiencing, for a second time, the severe occipital headache with which her attack was ushered in, and has just weathered the prodromal nightmare which in the beginning preceded the headache.

We have very rarely found it to be the case that convalescence, whether slow or rapid, is uninterrupted. Backward steps, so decided sometimes as to point to relapse, are more than likely to mark the road to recovery.

Danger of overstrain in mental application during convalescence from acute mania:—

It is not an unfrequent wish on the part of the patients

and their relatives that the mind may be stimulated and strengthened by light study and mental application of different kinds early in convalescence. This is liable to be harmful where the patient has been under the strain of intense morbid over-activity of the brain, as in cases of acute mania. It is often difficult to restrain such patients when they feel the return of their old energy and desire for work which, perhaps, was never properly controlled in health. Piano practice, which is often a strain on young and healthy minds, application to petty pieces of work involving much contriving, are not unfrequently followed by headache, lassitude, depression and a bad night, while interesting effort of a light kind in the open air requiring no special mental application, would be actually beneficial. Convalescents from melancholia, on the other hand, often require to be roused and stimulated, but there is danger of pushing even these patients too far if they manifest much opposition. A return of interest in life cannot, as many think, be forced. It should rather be courted and fostered where it appears.

Many convalescing cases, especially of confusional insanity and mental disorder following *la gpe*, must be treated on lines identical with those of nervous exhaustion. It is a great boon to such patients to be kept under the doctor's care, in order that they may have their confidence strengthened by frequent assurance and advice when the bad days or moments come, avoiding, however, carrying protection too far and fostering self-distrust in the patient's powers to the extent of hypochondria and invalidism. At the period of menstruation, particularly its end, the utmost quiet and rest is necessary for the patient convalescing from insanity, especially when one has had periodical exacerbations during the attack. This obvious precaution is often neglected.

Cases in which stay in asylum should be prolonged:—

We are now brought to the question of time of discharge from the physician's supervision, whether from the

asylum or other separate care away from the family. In the bulk of cases influence should be exerted by the family physician or other consultant against too early removal home or elsewhere, especially in melancholia with suicidal tendencies, no matter how remote, and in almost all cases of acute mania. In the latter, if at all possible, it is best to wait until recovery is complete, so great is the importance of rest to mind and body after the exhaustion peculiar to this form of insanity. Here travel and distraction are distinctly injurious during convalescence. But if such convalescents come under the care of the general practitioner he will protect them from all external irritating influences and when necessary secure complete quiet by sedatives. It is usually unwise where the patient is poor or in moderate circumstances to make a change during the remissions which occur in the course of general paralysis of the insane. The improvement is often however, so striking that it is difficult to persuade relatives of this. Even change to new but quiet surroundings, so beneficial in many cases in hastening recovery, is to be deprecated during convalescence from acute mania, owing to the difficulty of proper accommodation to new experiences and consequent tendency to mental disturbance.

When early discharge is desirable:—

But although delay is the usual and safe rule for the mass of insane convalescents, early removal often has a good effect in carefully selected individual cases, particularly melancholiacs. Homesickness often becomes during convalescence a fixed idea, or delusion otherwise, and the patient opposes treatment, sleeps poorly and loses flesh. When refusal of food has been a prominent symptom and the patient has begun to show material gain in other ways, early removal may be followed by his beginning to eat. The following is a case in point:

Merchant of 56 years of age, of high character and good ability—slight neuropathic heredity. No previous attack. About three years ago he came under the writer's care for

an attack of melancholia, with delusions of suspicion, of a few weeks' standing. He believed, without reason, that he had lost a large amount of money, that business and other friends distrusted and avoided him, etc., etc. Talked of committing suicide by drowning. Became uncommunicative and indifferent to his personal appearance and surroundings. Was greatly depressed and quite restless. Slept and ate but little. Soon suspected conspiracy on part of his family, refused to look at his letters and rapidly developed delusions of persecution and attempts to poison him by tampering with his food. Had slight hallucinations of sight. Resisted determinedly all attempts to dress and otherwise care for him. The usual threats of forced feeding and the various devices for encouraging voluntary eating failed and it became necessary to resort to feeding by tube. He remained for eight months without showing much gain except in physical condition, requiring to be fed artificially four times a day. He was morose and constantly on his guard, but was willing to go to drive and to walk. Did not recognize or feared to address even the members of his family. After several fruitless visits from his wife he at last spoke freely to her and appeared entirely rational on all points regarding home, family and business, but continued suspicious of physicians and nurses and believed that the walls of the house were about to fall in upon him. Utterly refused also to take food at request of his wife. She was accordingly directed to have a meal prepared and sent from the city. She and her daughter were then to dine with the patient in the grounds at a distance from and out of sight of the house. The experiment succeeded perfectly, but on his return to the house he made the usual opposition to taking a meal. I advised complete and immediate change, as his dangerous tendencies had disappeared and his remaining delusions referred only to the place where he was being treated. He was accordingly taken, in a few days, into the country and thence, after a few weeks of steady improvement, to his home in the West, where he soon recovered. He has remained well for two years. Here a complete and favorable change of surroundings early in convalescence at least facilitated recovery if it did not actually prevent the setting in of confirmed delusional insanity or dementia.

Other cases are the querulous convalescents with

morbidly increased anxiety about their health, finding new ailments each day. To such harm may come from the absence of change. As does Schüle, we occasionally meet with certain cases of mania of the reasoning type, *mania mitis*, who are irritated by asylum discipline, also protracted cases of mania who, even while convalescing, are independent, behaving badly because they are "in an asylum" and who feel that they may do as they like. The pressure of outside life steadies them and hastens recovery. A convalescing patient may also be removed earlier from a large institution, with its necessary restrictions and unfamiliar sights, scenes and surroundings, than from a smaller establishment where the life and surroundings are of a more domestic and natural kind, and where the gradual steps to normal ways of living may be taken while the patient is still under medical supervision. The nearer we approach to caring for and treating individually the insane patient, whether public or private, the more we appreciate the value of change to different and more natural surroundings when convalescence in the curable and mild dementia in the chronic insane sets in.

Recovered patients ; their critical condition for the first year after discharge—Precautions necessary:—

When the hospital is left behind, even after full recovery, the situation is often quite as critical, particularly for those who are poor or in difficult circumstances, for whom the adoption of special means of relief will be urged later. The first year after recovery is a most critical time. To prevent a recurrence of an attack, the previous one will often be a serviceable guide, and the question may come up as to the real cause and how it can be prevented from giving rise to another. If childbirth has been the cause there is a strong likelihood that no matter how good the recovery, a second parturition will be the source of another attack of insanity. Here it is plainly one's duty to point out the dangers of pregnancy, especially in cases where there have been two or more attacks of puerperal insanity. (Blandford). Oc-

casionally the means taken to lessen the severity of labor has seemed to be of service in aborting or modifying an attack. We have often to decide what, if any, occupation a young man should follow, and whether another should restrict, or abandon his former work. Well-defined cases of periodical insanity are apt to recover thoroughly, and in point of strength, control and rationality, seem to fully regain their health. It has been thought, however, that the short prodromal stage of physical symptoms, which is the counterpart of the same stage in preceding attacks, may be so treated by change or the administration of bromides that a relapse will be warded off. This is questionable, although some relief appears to have been given by these means. The cases of insanity which will not be benefitted by occasional visits to the physician during the first year or so after recovery are few. Many a growing depression has been prevented thereby from going farther. Finally, also, all the usual general rules for the prevention of insanity apply, obviously, with ten-fold force to those who have been once insane, or who are experiencing a remission in the course of general paralysis of the insane, and need not be repeated here.

Absence of any provision for the after-care and assistance of recovered and improved pauper patients discharged from asylums:—

It is now in order to show what has been done abroad and should be done in this country to aid the pauper insane on their discharge from hospitals. The work has been comparatively recent, and, as in other reforms for the sick and defective classes (barring the case of epileptics), the insane have come last. Most well-equipped *general* hospitals have convalescent departments, far removed from the main buildings, not to speak of the out-patient departments for the patient to return to in case of alarm on the re-appearance of his or her physical trouble. Of the very numerous convalescent homes and retreats at the command of charitable organizations not one is for the insane. Offenders discharged from prisons and reforma-

tories have long been encouraged and aided by societies for their relief, but the lunatic, apart from cottages on the premises of institutions for the insane, where a few convalescents are placed among mild cases of chronic insanity, or houses by the sea-shore in connection with a few private institutions—with these exceptions—there is nothing approaching special provision for convalescents from insanity. For the insane who have been discharged wholly or partially recovered, no means of supervision or assistance whatever are provided in this country, although their malady in itself alone is serious and disabling, even when not accompanied (as it often is) by physical debility or disease.

Absence of adequate advice to patients leaving hospitals:—

In States which are blessed by more charitable legislation, patients are, to be sure, given a new outfit of clothing, or perhaps a sum of money, but this is the utmost they receive. There are few institutions, moreover, where it is the rule to give precautionary advice to departing patients and their relatives. They receive, at best, a few general directions, while it oftener happens that their ^{discharge} ~~discharge~~ is unknown to the physician except by report.

Means employed for the after-care and assistance of pauper patients in foreign countries:—

A short review of what is being done in other countries in the way of the after-care of patients discharged from asylums, will best make clear the demand and reasons for such care, as well as the methods best adapted to secure it.

By the direction of the French Government, societies for the supervision and aid of insane patients on their discharge from asylums, are now being formed throughout that country. In a circular sent two years ago to the different prefects, the Minister of the Interior called attention to the fact that asylum physicians often hesitate to set certain patients at liberty, whose mental condition seems to have so far improved as to make it useless to keep this class (or even those who have recovered), longer

under treatment for fear that thus suddenly thrown on their own resources without oversight or, perhaps, without means of support, they will fall back into the old habits of life which gave rise to their insanity. This is particularly the case with those who, as often happens, are prevented from obtaining employment simply because they have been inmates of an asylum.

He advised that protective societies be formed for the oversight and assistance of such insane persons, through the first phases of their return to ordinary life.

The Superior Council of Public Charities, in the course of an inquiry into the proposed revision of the lunacy laws of France, have recently formulated a series of recommendations regarding these *Sociétés de Patronage* (aid societies), which are in effect as follows :

That the Minister of the Interior urge the various prefects to encourage the formation of societies for the purposes above described, in every possible way, in all the departments.

That it shall be the office of these societies to aid convalescent or recovered patients by the following means : gifts of money, clothing and tools (this assistance to be weekly, monthly or quarterly), redemption of articles in pawn, payment of rent, admission to convalescent homes in cottages intermediate between confinement and complete freedom, or in hospitals or houses of refuge ; finding situations for them in workshops, business houses, on farms, etc., and, finally, their supervision in whatever place they are employed.

That these societies be authorized to invest the savings of the insane and remit thereto the interest.

That the different societies be encouraged to co-operate.

The Minister expressed himself as heartily in favor of and ready to carry to consummation the views of the Council, and called for speedy information from the prefects as to the result of the operation of the project as well as suggestions for its furtherance. In consequence much has been done in France in this direction in the way of after-care since that time.

This general work throughout the entire republic is the outcome of other forms of after-care in operation in France since 1841, when an after-care association was formed for providing protection, assistance and homes, for poor insane convalescents, on leaving institutions for their treatment. It was founded by Dr. Falret. It was and is confined, however, to the department of the Seine. Its benefits are bestowed through three principal channels. (1) A central convalescent home the inmates of which are exclusively poor and friendless female convalescents. Their sojourn is temporary, not exceeding five or six weeks, during which time they have the advantage of kindly ministrations, and on leaving they are invited to revisit the home. (2) Another form in which after-care is exercised is in the *Rénios du Dimanche*. That is, on Sundays the "Home" welcomes as guests a certain number of mental convalescents, who may desire to spend some pleasant hours in the institution, where they lived for a season. Their children are welcomed; husbands often accompanying their wives. They are hospitably entertained and attend chapel service, walk in the grounds, etc. In the year 1888 1,441 persons, men, women and children, were received as Sunday guests into the home. (3) Assistance is also rendered to mental convalescents by visits to them in their own homes, especially in cases where occupation, illness or other causes, prevent them from coming to headquarters. The number of such domiciliary visits paid in that year was 845.⁴

In England the subject did not come up until 1879, when a paper by the chaplain of the Middlesex Asylum, Colney Hatch, on after-care appeared in the *Journal of Mental Science*. In that year the first meeting of the After-care Association was held. Its object was announced to be to facilitate the readmissions of female

⁴ For further information of the operations of the After-Care societies in France the reader is referred to an excellent and more detailed account from the pen of Dr. Victor Parant, of Toulouse, which appeared shortly after this paper was read in the *American Journal of Insanity* for July, 1884.

convalescents from lunatic asylums into social and domestic life. It appears that not until 1886 was there any practical work attempted. Working associates were then appointed, of which there are twenty, for the purpose of finding suitable homes for convalescents and visiting and reporting upon their temporary inmates. They also follow them up either to the poor-houses to which they have been discharged or to their own homes. Homes have been found where convalescents have been boarded out, the patient's oversight being entrusted to some lady in the neighborhood, and the homes are inspected before any case is sent and afterwards by a voluntary inspector. Nearly one hundred cases were helped since 1886, while during the years of 1888 and 1889 forty cases were brought before the committee. In nearly every case assisted suitable employment was afterward found. A large number of cases not coming under the rules of the association have been helped to obtain relief through other channels.

In Switzerland there exists a system of after-care in several cantons. Aid is given to convalescents from mental disorders by endeavoring to provide occupation, by pecuniary assistance varying from fifty to one hundred francs. The persons discovering cases in need of treatment report to the secretary. A voluntary subscription of two francs annually from individuals, supports the institution fund. These societies are much valued by the medical superintendents of the Swiss asylums.⁵

It really would seem an opprobrium that in our country convalescents from mental disease should receive only scant advice and practically no care on leaving asylums, and it would also seem that a public duty devolves upon the medical profession, especially those interested in mental diseases, and the fullest methods for their relief, to further such after-care. Certainly there can be no better object on the ground of humanity and public economy than practical effort toward a provision which may be a help in preventing the increase of insanity.

⁵ The above accounts are taken from Tuke's Dictionary of Psychological Medicine, and the Archives de Neurologie for 1882.

DISCUSSION.

Dr. E. D. FISHER said that he had listened with pleasure to this conservative paper, particularly the ideas about the early dismissal of the patients in suitable cases, and the retention of other cases. He thought the mistake was frequently made of allowing the patients to leave too soon. Where the delusions had disappeared, or where they were recognized as delusions by the patients themselves, and where there was the dread of the disgrace attendant upon being in such an institution, it was advisable to have them return to their homes. In answer to the question, "What shall we do with these patients after their dismissal?" he would divide the patients into two classes—those of the better class of patients, and the pauper insane. He was certainly heartily in favor of the idea of having some convalescent home for the former, and of some union between patients where they could return from time to time and be placed under the care of the physicians. This would often prevent a second attack after their dismissal. When a patient returned to a pauper asylum it was a pretty sure indication that he would remain there permanently. All could see the necessity for some sure measure as that proposed, and he heartily endorsed the suggestion.

Dr. F. X. DERCUM, of Philadelphia, said that this paper opened up a very important phase in the case of the insane. He was heartily in accord with the suggestion that institutions be established intermediate between the ordinary asylum and the outside world.

Dr. M. ALLEN STARR said that it was very difficult to decide just when patients should be taken out of asylums. He had sent some to water-cure asylums in order to make a break between asylums and home care. The families of these people were also very difficult to manage, for they sat around the patient, as though he were a curio and was going to explode. Travelling was detrimental. An intermediate institution, he thought, would be very good.

Dr. P. C. KNAPP, of Boston, heartily endorsed the views brought forward by Dr. Stedman. It was not uncommon to see, in the out-patient departments of general hospitals, patients who had formerly been in an insane asylum, but who, being unable at first to endure the trials of daily life, again manifested symptoms of

nervous and mental disease, which they might have escaped had they had proper care in the period immediately following their discharge.

Dr. C. L. DANA said that this question, upon which they all seemed so well agreed, was an economic rather than a strictly medical one. He suggested the appointment of a committee of three to investigate and report to the Association upon some feasible plan for establishing a form of treatment, which could then be recommended as a measure for adoption by the State. He thought this would be a practical advance in the desired direction.

The PRESIDENT then appointed Dr. H. R. Stedman, of Boston, Dr. F. X. Dercum, of Philadelphia, and Dr. C. L. Dana, of New York, to serve on this committee.

He said that as regards this idea of caring for the pauper insane, he was heartily in favor of it. In private practice, when a patient had been in hospital for a considerable time, and a change seemed desirable, he was accustomed to send the patient to the country in the charge of a competent person. The influence of a wholesome sane mind over an insane one was a great advantage. There were many delusions from which a patient could not be freed. Some can, however, be affected by constant association with a sane person. Within the last five or six years he had tried this plan of treatment with entire satisfaction. It should be carried well into the period of convalescence.

Dr. STEDMAN, in closing this discussion, said that the matter of primary and chief importance was the formation of protective associations for the discharged insane patients, which should, for a time, provide for their supervision and assistance in the ways indicated. This was the first step, and such work prosecuted with vigor would, he thought, yield practical results. He was not prepared to advocate separate convalescent establishments for this class. Suitable quarters in private dwellings could be found by such societies for the special cases needing further oversight. He felt extremely gratified with the prompt and practical response which the Association had made to his appeal.

